STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155718	B. WIN			04/18/2	011
		l .	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8		1	EST CROSS STREET		
СОММИ	NITY NORTHVIEW	CARE CENTER		1	SON, IN46011		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
'	This visit was fo	r the Investigation of	R	0000			
	Complaint IN00			,,,,,			
	Complaint 11400	000777.					
	Complaint INIOO	088797- Substantiated,					
	_						
	residential state	finding cited at R051.					
	D.4 A 3110.0	011					
	Date: April 18,2	011					
		00076					
	Facility number:						
	Provider number						
	AIM number:	100267150					
	Surveyor: Jeri C	Curtis, RN					
	Census bed type	<u>.</u>					
	SNF:	4					
	SNF/NF:	68					
	Residential:	25					
		97					
	Census payor typ	ne:					
	Medicare:	15					
	Medicaid:	45					
	Other:	37					
	Total:	97					
	Sample: 3						
	These state findi	-					
	accordance with	410 IAC 16.2.					
	Quality review c	completed on April 21,					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2MES11

Facility ID:

000562

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155718	B. WIN	G		04/18/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY NORTHVIEW	CARE CENTER		l	EST CROSS STREET SON, IN46011		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID			(V.5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	2011 by Bev Fau	lkner, RN					
R0051	any physical or ch for purposes of dis	e the right to be free from emical restraints imposed scipline or convenience and at the resident 's medical					
			RO	051	The Plan of Correction for R-0s will be to allow resident A and	B to	04/29/2011
	Based on	record review			move about freely without the of any physical or chemical restraints. The facility had take		
	and interv	iew, the			all of the footstools out of the building and will not be bringing		
	_	iled to assure			those back for use. The facility has also terminated three third	ĺ	
		of restraint by			shift staff and the DON for not following policy or protocol in the		
	the placen	nent of a foot			situation. Since all residents have the potential to be affected	ed	
	stool betw	een the bed			by this deficient practice, all standard been trained regarding ab	use	
		d mattress			by 04-10-2011. The facility has also scheduled a mandatory al		
		order to prevent			staff inservice with the Ombudsman pertaining to		
	ر ک	2 (Residents			resident rights and abuse for Monday, May 9th, 2011. The facility will hold an inservice 2:	v'e	
	A and B)	of 3 residents,			yearly pertaining to resident rig	ghts	
	reviewed	for use of a			and abuse. All documentation regarding these inservices will		
	restraint.				kept in the DON's office at Monticello House. The facility		
	Findings i	nclude:			train all staff on a new docume called "Administrative Alert" (s Attachment A). This form will guide staff on who and when to report an alleged abuse situati to. A record of all reports and investigations will be kept in th		

000562

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		A. BUI	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/18/2011		
AND PLAN	AME OF PROVIDER OR SUPPLIER  COMMUNITY NORTHVIEW CARE CENTER  (4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		LDING IG STREET A 1235 W	DON'S ORSTRUCTION  OO  ADDRESS, CITY, STATE, ZIP CODE (EST CROSS STREET SON, IN46011  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEPICIENCY)  DON'S office at Monticello House. The Administrator or DON will make unannounced rounds on the night shift at lea once monthly to ensure that residents are able to move ab- freely without the use of restraints. Documentation of these rounds will be kept in th- DON's office at Monticello House. All new staff will be trained regarding resident righ abuse and the administrative alert form. This will be done at orientation, prior to new staff working the floor. None of the staff who worked at the residential facility had ever worked at any part of our skille	04/18/2011  (X5) COMPLETION DATE  st  out  e  ts,	1	
	had initial use of una restraints of Long T	an employee ly reported the authorized to the Director erm Care at the Facility was a			Northview Care Center), the buildings are on the same campus but utilize separate st All information and documentation regarding this deficiency and the POC will be added to our QA meeting for review and changes to be mad necessary. The plan of correct date for this deficiency will be 04-29-2011.	de if	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SU COMPLE		
		155718	A. BUII B. WIN			04/18/20	11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY NORTHVIEW	CARE CENTER		1	SON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	16	DATE
		the facility was					
	restraint fi	ree and the					
	employees	s were					
	suspended	l pending an					
	independe	ent					
	investigat	ion.					
	The Admi	nistrator					
	indicated	following the					
	investigat	ion, the					
	employees	s, 2 certified					
	nursing as	sistants (CNAs					
	#1 and #2	), 1 Licensed					
		Nurse (LPN					
		ne Director of					
	, ,	DoN) were					
	terminated	<i>'</i>					
	The Admi						
		the employees					
		t shift. The					
	•	rator indicated					
	Aummsu	ator murcated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MI A. BUII		INSTRUCTION 00	(X3) DATE S COMPLI		
		155718	B. WIN	G		04/18/20	011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
COMMUI	NITY NORTHVIEW	CARE CENTER		1	SON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE I	DATE
	a decision was made to						
	also terminate the DoN						
	because sh	ne had					
	knowledge	e of the third					
	shift staff	placing objects					
	at the beds	side to prevent					
	the resider	nts from rising					
	in 1/11. Tl	he					
	Administr	rator indicated					
	the investi	igation process					
	determine	d the DoN did					
	not recog	nize					
	unauthoriz	zed restraint					
	use as abu	ise and failed					
	to report						
	to adminis	stration.					
	The Admi	nistrator					
	indicated	throughout the					
	investigati	ion, none of					
	the emplo	yees					
	*	-					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718			LDING	NSTRUCTION  00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	recognize	d the use of					
	unauthoriz	zed restraints					
	as abuse.	The					
	Administr	rator indicated					
	following	the					
	independe	ent					
	investigat	ion, all					
	employees	s were required					
	to attend a	n mandatory					
	inservice	on abuse					
	prevention	1.					
	The Admi	nistrator					
	indicated	the					
	investigat	ion did not					
	determine	the length of					
	use of the	foot stools as					
	restraints.	The					
	Administr	ator indicated					
	the time fi	rame had been					
	identified	as the fall of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155718		(X2) MUL' A. BUILDI B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			1235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	2010, thro	ough 3/11.					
	The record	d of Resident					
	(A) was re	eviewed at					
	10:00 A.N	<i>I</i> ., 4/18/11, and					
	indicated	a 7/07,					
	admission	with					
	diagnoses	including, but					
	not limited	d to,					
	Alzheime	r's dementia					
	and reacti	ve psychosis.					
	The 4/7/1	l weekly					
	nursing su	ımmary					
	indicated	(Resident A)					
	was alert 1	to					
	name,con	fused to time					
		and the needs					
	were met						
		,					
	The record	d of Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718			LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			1235 W	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(B) was re	eviewed at					
	10:35 A.N	<i>I</i> ., 4/18/11, and					
	indicated	a 3/10,					
	admission	with					
	diagnoses	including, but					
	not limite	d to,					
	Alzheimer's dementia						
	and macu	lar					
	degenerat	ion.					
	The 4/4/1	1, weekly					
	nursing su	ımmary					
	indicated	(Resident B)					
	was alert	to name,					
	unaware o	of time and					
	place, and	the wants and					
	needs wer	re anticipated					
	by staff.						
	At 11:20 the Admir	A.M., 4/18/11, nistrator					

000562

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155718		(X2) MU A. BUII B. WIN	LDING	00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		<b></b>	STREET A	ADDRESS, CITY, STATE, ZIP CODE VEST CROSS STREET RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	demonstra	ated how the					
	foot stool, a 4 legged,						
	rectangula	ar style, had					
	been place	ed between the					
	mattress a	and the bed					
	springs. T	he					
	Administrator placed the						
	foot stool,	upright, with					
	the 4 legs	placed in the					
	bed spring	gs at the foot of					
	the bed. T	he					
	Administr	rator indicated					
	this pushe	ed the foot of					
	the mattre	ess in an					
	upward po	osition,					
	preventing	g rising.					
	The Admi	nistrator					
	indicated	the greater					
	distance for	orward from					
	the foot of	f the bed the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	onstruction 00	(X3) DATE S COMPL		
		155718	B. WIN	IG		04/18/20	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		1	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION OF PROSS PREFERENCED TO THE PROVIDER OF T		_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
	stool was	placed would					
	further restrict resident						
	movemen	t.					
	The Admi	nistrator also					
	demonstra	ated the foot					
	stool place	ed with 2 legs					
	in the spri	ngs, under the					
	mattress, a	and 2 legs					
	hanging o	ver the edge of					
	the bed. T	he					
	Administr	rator indicated					
	this positi	on had been					
	shown by	1 of the					
	employees	s during					
	questionin	ng. The					
	Administr	rator indicated					
	this positi	on allowed					
	slightly m	ore freedom of					
	movemen	t while still					
	restraining	g the resident.					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DLAN OF CORRECTION IDENTIFICATION NUMBER: 155718			LTIPLE CO	NSTRUCTION  00	(X3) DATE COMPI 04/18/2	ETED
	PROVIDER OR SUPPLIER			1235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	At 12:50 I was intervited telephone indicated second shoccasional over until help night LPN #2 in September October, 2 had said some how the "remedied of (Reside up at night).	P.M., LPN #2 viewed by . LPN #2 she worked ift and lly would stay 3:00 A.M. to ts. ndicated in late or or early 2010, CNA #1 the would show he night shift, d the problem ent B) getting it."	P	I	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
	#1 lifted t	ndicated CNA he mattress of (B) placed 2					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE : COMPL		
		155718	B. WIN	IG		04/18/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		ANDER	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	ME.	DATE
	legs of the stool in the						
	springs un	nder the					
	mattress a	and attempted					
	to leave 2	legs hanging					
	over the e	dge of the bed.					
	LPN #2 in	ndicated it did					
	not work a	and CNA #1					
	crammed	all 4 legs of the					
	stool into	the bed springs					
	which hel	d the mattress					
	up in a res	strictive					
	position.						
	LPN #2 in	ndicated she					
	had report	ted the incident					
	to the Dol	N the next day.					
	LPN #2 in	ndicated the					
	DoN said	she thought					
	the practic	ee had stopped.					
	LPN #2 in	ndicated CNA					
	#3, who h	ad also worked					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718			LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		р. жих	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET ISON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	extra on the	ne night shift,					
	had told her she had						
	witnessed	the same					
	practice in	n 1/11. LPN #2					
	indicated	CNA #3 had					
	said she h	ad confronted					
	the night 1	nurse ( LPN					
	#1), and tl	ne CNA					
	(unidentif	ied) about the					
	practice.						
	LPN #2 in	ndicated she					
	told CNA	#3 she could					
	do nothing	g against					
	another lie	censed nurse					
	and sugge	sted (CNA #3)					
	go to the I	OoN.					
	LPN #2 in	ndicated the					
	DoN had	thought the					
	problem v	vas resolved,					
	found it w	as still going					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00		X3) DATE SURVEY COMPLETED 04/18/2011	
	PROVIDER OR SUPPLIER		STRE 1235	ET ADDRESS, CITY, S' S WEST CROSS S ERSON, IN46011	STREET	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION TIVE ACTION SHOULD BE NCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
	on, and ha	ad all the foot				
	stools rem	noved from the				
	facility.					
	At 1:00 P.	M., 4/18/11,				
	CNA #4 v	vas interviewed				
	and indica	ated she did				
	double sh	ifts and worked				
	nights 2 ti	mes a week.				
	CNA#4 in	dicated she				
	was aware	e of a foot stool				
	placed bet	ween the				
	mattress a	nd bed springs				
	to prevent	Resident (B)				
	from risin	g.				
	CNA #4 i	ndicated the				
	incident o	ccurred in late				
	December	, 2010, or				
	before. C	NA #4				
	indicated	she did not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE COMPL 04/18/2	LETED	
	PROVIDER OR SUPPLIER		p. wiik	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	report the	incident.					
	CNA #4 indicated CNA						
	#3 had als	o witnessed					
	the practic	ce and had					
	reported to	o the DoN.					
	CNA #4 i	ndicated all					
	foot stools were removed						
	from the f	acility after					
	that.						
	*	the facility's evestigation for					
	counseling DoN for I indicated						

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155718			LDING	DNSTRUCTION  00	l` ′	E SURVEY PLETED /2011
NAME OF I	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	•	
COMMU	NITY NORTHVIEW	CARE CENTER		1	RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	third shift was						
	attemptin	g to keep 2					
	residents	(A and B) in					
	bed at nig	th to prevent					
	falls. The	DoN indicated					
	it was rep	orted objects					
	had been	placed at the					
	bedside o	f residents to					
	keep then	n from getting					
	up at nigh	nt.					
	The DoN	counseled LPN					
	#1 all foo	t stools had					
	been rem	oved and no					
	objects w	ere to be placed					
	to impede	eresident					
	movemen	nt.					
	The DoN	documented					
	she had informed LPN						
	#1 of abu	se allegations					
	and asked	l if foot stools					

NAME OF PROVIDER OR SUPPLIER  COMMUNITY NORTH-VIEW CARE CENTER  INDUSTRIES ADDRESS, CITY, STATE, 2IP CODE  1235 WEST CROSS STREET  ANDERSON, IN-48011  SIMBALARY STATIMENT FOR PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Had been placed.  LPN #1 responded in the past objects had been placed to keep the residents with multiple falls in bed.  LPN #1 also responded it had not been successful.  The DoN counseled LPN  #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility).  The DoN documented LPN #1 verbalized understanding.		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 04/18/2	LETED
SUMMARY STATEMENT OF DEFICIENCY   PREJECT   TAG	NAME OF I	PROVIDER OR SUPPLIE	₹				•	
PRETIX TAG REGULATORY OR I SC IDENTIFYING INFORMATION)  had been placed.  LPN #1 responded in the past objects had been placed to keep the residents with multiple falls in bed.  LPN #1 also responded it had not been successful.  The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility).  The DoN documented LPN #1 verbalized						SON, IN46011		
LPN #1 responded in the past objects had been placed to keep the residents with multiple falls in bed.  LPN #1 also responded it had not been successful.  The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility).  The DoN documented LPN #1 verbalized	PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
past objects had been placed to keep the residents with multiple falls in bed. LPN #1 also responded it had not been successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		had been	placed.					
placed to keep the residents with multiple falls in bed. LPN #1 also responded it had not been successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		LPN #1 responded in the						
residents with multiple falls in bed. LPN #1 also responded it had not been successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		past object	ets had been					
falls in bed. LPN #1 also responded it had not been successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		placed to	keep the					
LPN #1 also responded it had not been successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		residents	with multiple					
it had not been successful.  The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		falls in be	ed.					
successful. The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		LPN #1 a	lso responded					
The DoN counseled LPN #1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		it had not	been					
#1 any attempts to restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		successfu	1.					
restrict resident movement would be viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		The DoN	counseled LPN					
movement would be viewed as a restraint which was against the policy of the (name of the residential facility).  The DoN documented LPN #1 verbalized		#1 any att	tempts to					
viewed as a restraint which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		restrict re	sident					
which was against the policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		movemen	t would be					
policy of the (name of the residential facility). The DoN documented LPN #1 verbalized		viewed as	a restraint					
the residential facility). The DoN documented LPN #1 verbalized		which wa	s against the					
The DoN documented LPN #1 verbalized		policy of	the (name of					
LPN #1 verbalized		the residential facility).						
		The DoN	documented					
understanding.		LPN #1 v	erbalized					
		understan	ding.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		A. BUII	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	LDDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	100.2	···
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		, statement by					
		ndicated a					
	•	as held with					
		hift staff, LPN					
	#1, and C	NAs #1 and 2,					
	to discuss	allegations of					
	using pillo	ows to keep					
	people in	bed.					
	The DoN	documented					
	she inforn	ned the 3 she					
	had not be	en notified by					
	her superi	ors of any					
	investigat	ion into alleged					
	abuse. The	e DoN					
	indicated	all 3 denied					
	allegation	s of abuse.					
	On 3/30/1	1, the Long					
		e Director had					

000562

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MUI A. BUILD B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL	ETED	
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	•	
	NITY NORTHVIEW				SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	document	ed a memo to					
	the DoN i	ndicating she					
	was going	g to speak to					
	LPN #2 a	nd CNA #3 the					
	next day t	to see how the					
	foot stool	s were placed.					
	The Long	Term Director					
	document	ed she had					
	gone to th	e room of					
	Resident (	(A) and had					
	lifted the	mattress to					
	look at the	e springs. The					
	Long Terr	m Director					
	indicated	she was not					
	sure how	the foot stool					
	would fit	through the					
	springs.						
	The Long	Term Care					
	Director of	locumented she					
	was glad	the DoN had					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	been able	to speak with					
	her on $3/3$	0/11, instead					
	of waiting	until 3/31/11,					
	for the dis	cussion.					
	written by indicated end of the third shift came on controld (Resibeen attended out of bed indicated the resider sounded.  CNA #7 do CNA #6 s	in 9/10, at the second shift, a CNA (#6) luty and was dent B) had apting to get CNA #7 minutes later					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 04/18/20	ETED	
		1557 16	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/10/20	
	PROVIDER OR SUPPLIER				EST CROSS STREET		
(X4) ID	NITY NORTHVIEW	TATEMENT OF DEFICIENCIES		ID	SON, IN46011		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		lsc identifying information)		TAG	DEFICIENCY)		DATE
	kept Resident (B) from						
		t of bed on					
	nights. CN						
	document	ed CNA #6					
	took a foo	t stool and					
	placed it u	ınder the					
	mattress.						
	CNA #7 d	ocumented the					
	foot of the	e mattress was					
	lifted and	the foot stool					
	placed bet	ween the					
	mattress a	nd the springs					
	to keep Re	esident (B) in					
	bed.						
	CNA #7 d	ocumented					
	Resident (	(B) was up					
	against the	e wall and					
	could not move after the						
	foot stool	was placed.					
		ocumented the					
	OTATIII A	o continued the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 04/18/2011
	PROVIDER OR SUPPLIER		1235 W	ADDRESS, CITY, STATE, ZIP CODE VEST CROSS STREET RSON, IN46011	-
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	foot stool	was placed			
	with the k	nowledge of			
	the third s	hift nurse			
	(LPN #1).				
	CNA #7 d	locumented she			
	believed t	he foot stool			
	was place	d to keep			
	Resident (	(B) in bed and			
	not for pro	otection.			
	A 3/31/11	, statement was			
	written by	CNA #3			
	about the	9/10,			
	witnessed	incident of			
	CNA #6 p	lacing a foot			
	stool betw	veen the			
	mattress a	and the springs			
	at the foot	t of the bed of			
	Resident (	(B) to prevent			
	rising.	_			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
	PROVIDER OR SUPPLIER		<b>P</b> . W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE LEST CROSS STREET LSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	CNA#3 de	ocumented					
	CNA #6 h	ad					
	demonstra	ated during the					
	second to	third shift					
	change an	d had said					
	it was their	ir (3rd shift)					
	way of keeping the						
	resident in	n bed. CNA #3					
	indicated	she, LPN #2,					
	and CNA	#7, had					
	witnessed	the foot stool					
	placed.						
	CNA #3 d	ocumented					
	after place	ement of the					
	foot stool,	Resident (B)					
	could not	move at all.					
	CNA #3 d	ocumented she					
	had report	ted the incident					
	to the Dor	the next day.					
	CNA #3 ii	ndicated she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE : COMPL		
		155718	A. BUII B. WIN			04/18/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER			RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	had not se						
	placement						
	to restrict	movement					
	again unti	1 1/11.					
	CNA #3 d	ocumented					
	she did a l	oed check with					
	the third s	hift and					
	witnessed	CNA #1 place					
	a foot stoo	ol between the					
	mattress a	nd springs of					
	the bed of	Resident (A).					
	CNA #3 d	ocumented she					
	told CNA	41 it was					
	wrong. Cl	NA #3					
	document	ed CNA #1					
	replied, "i	t keeps him					
	from getti	ng up." CNA					
	#3 indicat	ed she reported					
	the incident to the DoN						
	the next d	ay.					
		•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE SEST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	CNA #3 d	ocumented a					
	few weeks	s later, CNA #1					
	and LPN a	#1 came on					
	duty, cloc	ked in, and					
	went strai	ght to the room					
	of Resider	nt (A) and					
	placed the	e foot stool					
	between the	he mattress and					
	bed spring	gs.					
	CNA #3 d	ocumented					
	CNA #1 h	ad come into					
	the dining	room and had					
	told the se	econd shift,					
	"there we	fixed him so					
	he can't ge	et up."					
	CNA #3 ii	ndicated LPN					
	#1 had sai	d they had					
	placed the	foot stool					
	under the	mattress to					
	keep (Res	ident A) in and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MUI  A. BUILD  B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			1235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	he (Reside	ent A) was					
	mad.						
	CNA #3 ii	ndicated she					
	was upset	and reported					
	the incide	nt to the Don					
	the next d	ay and the foot					
	stools were removed.						
	A 3/31/11	, statement					
	written by	LPN #2					
	indicated	at the					
	beginning	of 10/10, she					
	had witne	ssed third shift					
	staff place	a foot stool in					
	the bed sp	rings of					
	Resident (	(B) to keep					
	(Resident	B) in bed.					
	LPN #2 de	ocumented she					
	had gone	to the DoN the					
	<u> </u>	and reported					
		_					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION  00	(X3) DATE S COMPL		
		155718	A. BUII B. WIN			04/18/2	011
NAME OF P	PROVIDER OR SUPPLIER		'	1	ADDRESS, CITY, STATE, ZIP CODE /EST CROSS STREET		
СОММИ	NITY NORTHVIEW	CARE CENTER		1	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the incide	nt.					
	On 4/1/11	, LPN #1 had					
	written a s	statement					
	regarding	the positioning					
	of residen	ts on third					
	shift.						
	LPN #1 in	ndicated she					
	had receiv	red a text					
	message f	rom CNA#1					
	on 3/28/11	l, which said					
	there was	drama going					
	on at work	k. LPN #1					
	document	ed she had					
	returned a	call to CNA					
	#1 who sa	id the night					
	watch man	n had gone to					
	the Long	Term Care					
	Director v	vith a report					
	staff on th	ird shift were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MU A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE: COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER		p. wirte	STREET A	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	using pillo	ows to prop					
	residents.						
	LPN #1 de	ocumented she					
	had placed	d a call to CNA					
	#2, was or	n her way to					
	work whe	n he returned					
	the call, and he came to						
	the facility	y to meet with					
	herself (L	LPN #1) and					
	CNA #1.						
	Document	tation by LPN					
	#1 indicat	ed both she					
	and CNA	#1 had placed					
	calls to the	e DoN to find					
	out what v	was happening					
	and neithe	er had heard					
	back prior	to reporting					
	for work 3	3/28/11.					
	LPN #1 de	ocumented at					
	12:30 P.M	1., 3/28/11,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		A. BUII	LDING	NSTRUCTION  00	(X3) DATE S' COMPLE 04/18/20	ETED
		D. WIN	STREET A	EST CROSS STREET		
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
while on c	luty, she					
received a	call from					
CNA #5 w	who repeated					
the same i	nformation as					
CNA #1 h	ad provided.					
CNA #5 a	lso indicated					
she was supposed to call						
the Long	Term Care					
Director tl	he morning of					
3/29/11, a	nd did not					
want to m	eet with the					
her (the D	irector).					
LPN #1 de	ocumented she					
and CNA	s #1 and #2					
decided to	meet with the					
DoN on 3	/29/11 to					
discuss the	e issue.					
The aftern	oon of					
4/18/11, th	ne independent					
	rovider or supplier Summary's (EACH DEFICIENT REGULATORY OR While on Control of the Same in CNA #5 with the same in CNA #5 as she was sufficient to the Long of Director to the Same to make the Long of Director to the Director to the Director to the Director to make the Long of Director to the Director to make the Long of Director to the Director to make the Long of Director to make the D	OF CORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  While on duty, she received a call from CNA #5 who repeated the same information as CNA #1 had provided. CNA #5 also indicated she was supposed to call the Long Term Care Director the morning of 3/29/11, and did not want to meet with the her (the Director).  LPN #1 documented she and CNAs #1 and #2 decided to meet with the DoN on 3/29/11 to discuss the issue.  The afternoon of	ROVIDER OR SUPPLIER  STREET A 1235 W ANDER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  While on duty, she received a call from CNA #5 who repeated the same information as CNA #1 had provided. CNA #5 also indicated she was supposed to call the Long Term Care Director the morning of 3/29/11, and did not want to meet with the her (the Director).  LPN #1 documented she and CNAs #1 and #2 decided to meet with the DoN on 3/29/11 to discuss the issue.  The afternoon of	STREET ADDRESS, CITY, STATE, ZIP CODE   1235 WEST CROSS STREET   1235 WEST CROSS STREET   ANDERSON, IN46011   1235 WEST CROSS STREET   ANDERSON, IN46011	DENTIFICATION NUMBER:   155718   Dentification number:   155718   Dentification number:   15718   Dentification number:   15718   Dentification number:   1235 WEST CROSS STREET   235 WEST CROSS ST

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER		P. W.	STREET A	ADDRESS, CITY, STATE, ZIP CODE SEST CROSS STREET SON, IN46011	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	investigat	ion of the					
	alleged restraining of						
	residents	with foot stools					
	placed und	der the					
	mattress to	o prevent					
	rising, wa	s provided by					
	the Administrator.						
	The invest	tigation was					
	conducted	l by the					
	Network I	Manager (#1)					
	of the hos	pital which					
	owned the	e residential					
	facility.						
	Network I	Manager #1					
	interviewe	ed CNA #2 on					
	4/5/11, an	d documented					
	he replied	he had always					
	been able	to position					
	residents l	by placing a					
	pillow und	der pad to					

000562

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPI		
		155718	B. WIN	LDING NG		04/18/2	011
NAME OF I	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	•	
COMMU	NITY NORTHVIEW	CARE CENTER			SON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	assure the	skin was not					
	damaged.						
	CNA #2 i	ndicated he had					
	never witi	nessed LPN #1					
	place pillo	ows to keep a					
	resident in	n bed.					
	CNA #2 i	ndicated he and					
	LPN #1 h	ad placed a					
	foot stool	in the springs					
	at the end	of the bed of					
	Resident A	A). CNA #2					
	indicated	LPN #1 had					
	placed the	e stool and he					
	just helpe	d.					
	CNA #2 i	ndicated it was					
	bad judge	ment on their					
	part.						
	Network 1	Manager #1					
	interviewe	ed CNA #1 on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155718		(X2) MULT A. BUILDI B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/18/20	ETED	
	PROVIDER OR SUPPLIER			1235 W	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	4/6/11, an	d documented					
	a response	e from her of					
	never hav	ing placed a					
	foot stool.						
	Documen	tation indicated					
	CNA#1 h	ad replied she					
	had assisted LPN #1 by						
	holding th	e mattress for					
	placement	t of the foot					
	stool.						
	Documen	tation indicated					
	CNA #1 s	aid the purpose					
	was protec	ction, not					
	restraint.						
	Network I	Manager #1					
	also docui	mented a					
	4/6/11, int	erview with					
	LPN #1. I	Documentation					
	indicated	LPN #1 arrived					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718			LDING	ONSTRUCTION  00	(X3) DATE COMP 04/18/2	LETED	
NAME OF I	PROVIDER OR SUPPLIE	R	•	1	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	•	
COMMU	NITY NORTHVIEW	/ CARE CENTER		1	SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	with sun	glasses and					
	indicated	she had a light					
	sensitivity	y. LPN #1 also					
	indicated	she had kept					
	the lights	off at night					
	while on	duty to provide					
	a quiet en	vironment for					
	residents.						
	Documen	tation indicated					
	LPN #1 r	esponded to					
	allegation	s by the night					
	watchmai	n of draping a					
	curtain ac	cross the front					
	lobby sitt	ing area and					
	using con	nputers for					
	personal i	use. LPN #1					
	indicated	the purpose of					
	the curtain, and bringing						
	in computers, was for						
	break tim	es					
							1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE S COMPL		
		155718	B. WIN	IG		04/18/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET		
COMMUI	NITY NORTHVIEW	CARE CENTER		1	RSON, IN46011		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Document	tation indicated					
	LPN #1 de	enied the					
	computers	s were used to					
	access e-b	oay or play					
	games wh	ile on duty.					
	Document	tation indicated					
	when ques	stioned about					
	the use of	foot stools,					
	LPN 1# in	nitially					
	responded	l it was gossip					
	from co-w	orkers about					
	third shift						
	Document	tation indicated					
	LPN #1 ha	ad also said she					
	had been o	on the					
	telephone	with the DoN					
	3 days ago	o. LPN #1					
	indicated	the DoN had					
	said while	I have you on					
	the line w	hat is the issue					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/18/2	LETED	
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>		ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET	<u>'</u>	
COMMU	NITY NORTHVIEW	CARE CENTER		SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	with foot	stools.				
	Documen	tation indicated				
	LPN #1 h	ad responded				
	yes, foot s	stools had been				
	used a fev	v times,				
	however,	not to keep				
	residents	in bed.				
	Documen	tation indicated				
	LPN #1 h	ad responded				
	with only	2 staff on at				
	night they	had to slow				
	residents	and prevent				
	falls. Doc	umentation				
	also indic	ated the Don				
	had told I	LPN #1 not to				
	do that ag	ain.				
	Documen	tation indicated				
	when ask	ed the time				
	frame of t	the use of the				
	foot stool	s, LPN #1 had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155718		(X2) MU: A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL 04/18/2	ETED	
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE EST CROSS STREET SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	replied wi	thin the past					
	year. LPN	#1 indicated					
	she took f	ull					
	responsibi	ility.					
	Document	tation indicated					
	LPN #1 al	lso said she had					
	spoken with the DoN						
	about the	use of pillows					
	with resid	ents, "a long					
	while back	k." LPN #1					
	indicated	the DoN had					
	understoo	d and did not					
	see pillow	rs as a means of					
	restraint.						
	The in-ser	vices from					
	4/10 throu	igh 4/11, were					
	provided l	by the					
	Administr	ator 4/18/11.					
	Resident 1	rights and					

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	(X2) MULTI A. BUILDIN B. WING		NSTRUCTION  00	(X3) DATE S COMPL 04/18/2	ETED	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY NORTHVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1235 WEST CROSS STREET  ANDERSON, IN46011					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	abuse pro							
	inservices	were not						
	provided.							
	Document	tation indicated						
	the first al	ouse inservice						
	were the o	ones provided						
	4/1-4/10/1							
	investigat							
	allegation	s of foot stools						
	as restraints and resident							
	abuse.							
	Neglect, A Involuntar Policy wa 4/18/11. T	and ion of Alleged Abuse and ry Seclusion s provided						
	indicated	uiiy iaciiity						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155718	B. WIN	G		04/18/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE EST CROSS STREET			
COMMUNITY NORTHVIEW CARE CENTER				1	SON, IN46011			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
TAG			-	TAG	DEFICIENCY)			
	employee who							
	witnesses, or in any							
	manner, was made							
	aware of a	any neglect,						
	verbal abu	ise, sexual						
	abuse, physical abuse,							
	mental abuse,							
	involuntary seclusion,							
	misappropriation of							
	property, or							
	un-witnes	sed physical						
	injury, was obligated to							
	report imr	nediately to a						
	nursing supervisor. The							
	nursing supervisor was to complete a form							
	(unspecifi	ed) and had						
	carry it to	the						
	Administr	ator, or during						
	off hours, place in the							

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155718	A. BUI	LDING	NSTRUCTION 00	(X3) DATE: COMPL 04/18/2	ETED	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY NORTHVIEW CARE CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE  1235 WEST CROSS STREET  ANDERSON, IN46011					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	appropriate mail box.							
	A copy wa	as also to be						
	placed in	the DoN's mail						
	box							
	****Any	case of						
	witnessed	staff to						
	resident abuse or any							
	severe or unusual							
	situation should be							
	reported to the DoN							
	immediate	ely. Do so by						
	phone during off hours.**** The Administrator or designee completes and documents an							
	investigati	ion of the						
	allegation							
	This state	residential rule						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155718		(X2) MULTIPLE CC  A. BUILDING  B. WING	00		E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY NORTHVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1235 WEST CROSS STREET ANDERSON, IN46011				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
		Complaint					
	IN000887	97.					